LOUISIANA
Department of
HEALTH and
HOSPITALS

UNISYS

ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid Program)

Basic Enrollment Packet

(Common Forms for All Provider Types)

(Enrollment packet is subject to change without notice)

Frequently Asked Questions

Q. How long does it take to process an enrollment application?

A. Unisys Provider Enrollment processes and completes the enrollment process within three (3) weeks of receipt of a correctly completed application.

Q. What if my application is incomplete or inaccurately completed?

A. If the application is incomplete or contains inaccurate information, a reject letter will be prepared explaining the problems and the entire application will be sent to the Pay-To address on file (or on the application for new enrollments). Once the provider corrects the errors and resubmits the application, the processing time begins anew.

Q. Why is the entire application rejected if it is incomplete or inaccurate?

A. Due to the volume of mail received by the Provider Enrollment Unit, it is impossible to match separate documents to a given application. To eliminate the possibility of documentation being lost, all paperwork is returned with a cover letter explaining the reason(s) for reject. After correction, all paperwork should then be resubmitted for processing.

Q. What are common reasons why applications are rejected?

A. Most applications are rejected because of missing information and incomplete ownership Information. Review the instructions and checklist and ensure that all necessary forms are included prior to submission.

Q. Can I fax my application to Provider Enrollment for processing?

A. No. All forms require an original signature (no stamps or initials) before the application may be processed. It is helpful to have all signatures completed in colored ink (not black) to eliminate the concern of copied signatures.

Q. Should I send my application via express or certified mail?

A. It is acceptable to send applications via express or certified mail, but it is not required and does not decrease the processing time.

Q. How will I be notified of my new Louisiana Medicaid provider number?

A. Once the enrollment process is complete, a letter will be generated and sent to the Provider at the Pay-To address on file. The letter will include the Louisiana Medicaid provider number and the effective date of enrollment.

Q. Can I obtain my letter notifying me of my Louisiana Medicaid provider number via fax, phone inquiry, or in person?

A. No. Current policy requires that this letter be mailed to the Pay –To Address on file.

Q. Do some provider types require processing time greater than 3 weeks? These applications may require additional time for processing:

- EPSDT Health Services
- Federally Qualified Health Center
- Hemodialysis
- Hospitals
- KIDMED Screening Clinic
- Out-of-State Ambulance
- Pharmacies
- Rural Health Clinics

Q. Should I hold claims until my Medicaid number is issued?

A. Yes. No claims can be processed until a Louisiana Medicaid provider number is issued. Timely filing requirements must be met.

Q. If I don't know what my Louisiana Medicaid provider number is, how can I obtain this information? How do I verify if I have an active Louisiana Medicaid provider number?

A. You may submit an inquiry in writing to Unisys Provider Enrollment, PO Box 80159, Baton Rouge, LA 70898-0159. The inquiry should include your Name, address and telephone number. A letter with your provider number will be generated and mailed to the Pay-To address on file.

Q. Why is my Louisiana Medicaid provider number closed?

A. Provider numbers are routinely closed for various reasons including returned mail and periodic closures of providers who have not been active for an eighteen (18)-month period. Activity includes claim submissions, providing services, etc. Once a number is closed for inactivity, a complete enrollment packet is required to reactivate the number.

Q. If I should have to contact Unisys Provider Enrollment about my application, what name should I give the representative to facilitate their retrieval of my application?

A. The name given should match the name submitted in Section A of the PE-50 form. It is imperative that the phone representative be given the full and correct name to locate the proper application.

Q. I am an individual who has a Louisiana Medicaid provider number. Who is responsible for my provider number?

A. The individual whose name is given as the Provider Name is ultimately responsible for all activity related to that number. All fraudulent activity is the responsibility of the owner of the number, not the billing party. Linkages to groups requires the express, written consent of the individual.

Q. What IRS documents are acceptable?

A. A copy of any IRS-printed document showing the business or individual name on IRS files along with Taxpayer Identification Number is acceptable.

Q. Can I call the Provider Enrollment Help Desk to obtain information on Group Linkages and EMC Submitter Number linkages?

A. No. You may, however, call to obtain the necessary form that is to be completed and submitted for this information. These requests are processed with other requests and have a turnaround time of up to 3 weeks.

Q. How does my address, phone number, and other information get updated when changes occur?

A. You should go to www.lamedicaid.com under the Provider Enrollment link and obtain an Address/Telephone Change Packet. Review it in its entirety to ensure that all required paperwork is submitted.

Q. Is Electronic Funds Transfer (Direct Deposit) required for enrollment in Louisiana Medicaid?

A. Yes.

Q. Should I update my Direct Deposit prior to closing my old bank account?

A. Yes. All direct deposits are transmitted to the bank account information on file. When the account is closed, the money has to travel back through the banking system before it can be released. This can take several weeks to rectify.

Q. How do I update my Direct Deposit information?

A. A MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT must be completed and submitted with a voided check to update the Direct Deposit information on file. Deposit slips are not accepted as they often have a different routing number from a checking or savings account. If a voided check is unavailable, a letter on bank letterhead identifying the ABA routing number, account number and type of account may be substituted.

Q. If I don't receive my direct deposit, who should I call?

A. You should first contact the Automated Clearinghouse (ACH) representative at your bank. If the bank is unable to locate the deposit, check to ensure that the account has not been closed or changed. Finally, if still unable to locate a deposit, call Unisys Provider Enrollment.

Q. Should I call Unisys Provider Enrollment to verify the accuracy of a letter received from Louisiana Medicaid?

A. If the letter was generated with the Unisys logo, it is not necessary to verify its contents.

Q. Where should I call about denied claims?

A. Call Unisys Provider Relations at 800/473-2783 or 225/924-5040.

Q. How do I obtain a Billing Manual for my provider type?

A. A Billing Manual is automatically mailed to the Pay-To Address within 3 to 4 weeks of the enrollment process being completed. The most recent Training Manuals are available on http://www.lmmis.com/provweb1/ProviderTraining/packets/providertrainingindex.htm. If manual is not received within 30 days of completed enrollment, please contact Unisys Provider Relations at 800/473-2783 or 225/924-5040.

Q. Does Louisiana Medicaid supply claim forms?

A. Claims submitted on UB-92s, HCFA 1500s and ADA Dental Forms are not supplied by Louisiana Medicaid and are available commercially. All proprietary forms required for other claim types can be obtained by calling Unisys Provider Relations at 800/473-2783 or 225/924-5040.

Statutorily Mandated Revisions to all Provider Agreements

A memorandum signed by Thomas D. Collins, Medicaid Director, to all Medicaid Enrolled Providers dated August 12, 1999 states:

"The 1997 Regular Session of the legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

"MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437:14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

1) comply with all federal and state laws and regulations;
2) provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
3) have all necessary and required licenses or certificates;
4) **maintain and retain all records for a period of at least five (5) years;**
5) allow for inspection of all records by governmental authorities;
6) safeguard against disclosure of information in patient medical records;
7) bill other insurers and third parties prior to billing Medicaid;
8) report and refund any and all overpayments;
9) accept payment in full for Medicaid recipients providing allowances for copay authorized by Medicaid;
10) agree to be subject to claims review;
11) the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
12) notification prior to any change in ownership;
13) inspection of facilities; and
14) posting of bond or letter of credit when required.

"MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

"The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

"The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

"Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify provider enrollment in writing within ten (10) working days of the date of this letter that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL."

Office for Civil Rights Policy Memorandum

A memorandum signed by Thomas D. Collins, Medicaid Director, to all Enrolled Medicaid Providers dated August 12, 1999 states:

"The Department of Health and Human Services, Office for Civil Rights, recently issued a policy memorandum regarding nondiscrimination based on national origin as it relates to individuals who are limited-English proficient. Enclosed is the Health Care Financing Administration (HCFA) Civil Rights Compliance Statement which expresses our Agency's commitment to ensuring that there is no discrimination in the delivery of health care services through HCFA programs.

"We have committed ourselves to full compliance with the requirements contained in this policy statement. As our partner with the administration of the Medicaid program, you likewise are obligated to comply with those statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The Office for Civil Rights of the Department of Health and Human Services has previously advised HCFA that detailed implementation regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

"It has been asked that we share this policy statement with you and what you do likewise with health care providers and all others involved in the administration of HCFA programs.

Health Care Financing Administration (HCFA) Civil Rights Compliance Policy Statement

"The Health Care Financing Administration's vision in the current Strategic Plan guarantees that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all HCFA program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of HCFA funds. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all HCFA operating components. Promoting attention to and ensuring HCFA program compliance with civil rights laws are among my highest priorities for HCFA, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of HCFA programs.

"HCFA, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. HCFA will, with your help, continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

"To achieve its civil rights goals, HCFA will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities including: collecting data on access to, and the participation of minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing HCFA publications, program regulations, and instructions to assure support for civil rights; and working closely with the Department of Health and Human Services (DHHS), Office for Civil Rights, to initiate orientation and training programs on civil rights. HCFA will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

"DHHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, HCFA will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

"HCFA's mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries; i.e., our customers. We will enhance our communication with constituents, partners and stockholders. We will seek input from health care providers, states, contractors, and DHHS Office for Civil Rights, professional organizations, community advocates and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability"

State of Louisiana

Instructions for Louisiana Medicaid PE-50 Provider Enrollment Form

PREPARATION

Please read the instructions in their entirety before completing forms. Complete Form PE-50 as an **original** document. The completed form may be photocopied for your records. Inaccurate/Incomplete forms will be returned to you for completion.

GENERAL INFORMATION

A Medicaid provider number will be issued to the individual or entity whose name appears in Section A of this form. It is the responsibility of this individual or entity to maintain accurate information on the Louisiana Medicaid provider file through submitting updates (as required) to the Provider Enrollment Unit. No changes will be made to any information on the Louisiana Medicaid provider files without an accompanying original signature of the provider or its designated representative.

Individual Provider Number – a seven-digit Medicaid provider number issued to individuals who meet all eligibility requirements. This number is used for billing purposes.

An individual Medicaid provider number can have only one (1) Pay-To address. Therefore, this address **MUST** be the address that the individual wishes to receive all Remittance Advice notices for claims billed under this individual number. For those providers who provide services at multiple locations, this address should be the address of the individual's main location.

Professional Group Provider Number – a seven-digit Medicaid provider number issued to any professional group who meets all eligibility requirements. This number is then used for billing purposes.

Linkages of Professionals to Groups – an individual's provider number can be "linked" to a group provider number for purposes of billing services provided under the relationship with the individual and the group.

- **Active providers only require Linkage Form, LNK-01**
- **New/Inactive/closed providers require a completed application and Form LNK-01**

Claims submitted under the group number, with an individual's number included as the attending provider, will be processed and the remittance will be sent directly to the group's Pay-To address. ***It is not necessary for the individual's Pay-To address to be the same as the Group's Pay-To address for these Remittance Advice notices to be sent to the group if billed correctly.***

The following fields **MUST** be completed:

Medicaid Provider Number – your seven- (7) digit Medicaid provider number, if known. Indicate if this application is for a new enrollment or an update to an existing enrollment. A new enrollment is for an individual or entity with no prior Louisiana Medicaid provider number. An update to an existing enrollment is for an individual or entity that has had a Louisiana Medicaid provider number in the past and that number is either closed or contains old information.

Is this a Change of Ownership (CHOW)? – indicate whether or not this entity has had a change of ownership that has not been reported to Louisiana Medicaid.

** The Department of Health and Hospitals has defined a change of ownership (CHOW) as any change in:

1. Name;
2. Ownership; or
3. Management.

This definition remains in effect even if the Internal Revenue Service, Secretary of State or Medicare does not recognize the change as a CHOW. Any change that meets the criteria above requires a full enrollment packet for updates to the Louisiana Medicaid provider file.

SECTION A – INDIVIDUAL / ENTITY INFORMATION & PHYSICAL LOCATION

Provider Name – enter the provider name according to the following guidelines:

- If the application is for an individual, enter the individual's name in this field (must match license name, if applicable).
- If the application is for a professional group, enter the group name under which the group does business in this field.
- If the application is for a business, enter the business name in this field (must match license name if applicable).
- If the application is for a pharmacy, enter the name under which the pharmacy permit is issued.
- If the application is for a long-term care facility, enter the name under which the facility does business (must match license name).

Area Code and Telephone # - enter the telephone number at the physical location of the business or individual named in the *Provider Name.*

Social Security Number – enter the social security number assigned to the owner of the business identified in the *Provider Name* field (not required if the name in *Provider Name* is an entity).

Physical Street Address - enter the physical location address of the business named in *Provider Name.*

Mailing Address (if different) – enter the mailing address if mail cannot be received at the Physical Street Address. For example, if the Physical Street Address is 123 Main Street, Anywhere, LA but mail cannot be received there, enter the mailing address such as PO Box 85555, Anywhere, LA.

Physical City – enter the city in which your *Physical Street Address* is located.

Mailing Address City – enter the city in which your *Mailing Address* is located.

Physical State – enter the state in which your *Physical Street Address* is located.

Mailing Address State – enter the state in which your *Mailing Address* is located.

Physical Zip Code – enter the zip code in which your *Physical Street Address* is located.

Mailing Address Zip Code – enter the zip code in which your *Mailing Address* is located.

Parish/County – enter the parish / county in which your *Physical Street Address* is located.

Code – the parish code of your physical location (see list below and enter appropriate code for the parish entered in the *Parish* field).

Parish Codes

Acadia	01	E. Baton Rouge	17	Madison	33	St. Landry	49
Allen	02	E. Carroll	18	Morehouse	34	St. Martin	50
Ascension	03	E. Feliciana	19	Natchitoches	35	St. Mary	51
Assumption	04	Evangeline	20	Orleans	36	St. Tammany	52
Avoyelles	05	Franklin	21	Ouachita	37	Tangipahoa	53
Beauregard	06	Grant	22	Plaquemines	38	Tensas	54
Bienville	07	Iberia	23	Pointe Coupee	39	Terrebonne	55
Bossier	08	Iberville	24	Rapides	40	Union	56
Caddo	09	Jackson	25	Red River	41	Vermillion	57
Calcasieu	10	Jefferson	26	Richland	42	Vernon	58
Caldwell	11	Jefferson Davis	27	Sabine	43	Washington	59
Cameron	12	Lafayette	28	St. Bernard	44	Webster	60
Catahoula	13	Lafourche	29	St. Charles	45	W. Baton Rouge	61
Claiborne	14	LaSalle	30	St. Helena	46	W. Carroll	62
Concordia	15	Lincoln	31	St. James	47	W. Feliciana	63
DeSoto	16	Livingston	32	St. John	48	Winn	64

Out-Of-State Hospital Providers (Arkansas, Mississippi, and Texas), & DME see next page before completing:

Texas	87	Mississippi	88	Arkansas	89	Other	99

Out of State Hospital & DME Trade Areas (2005)

Arkansas Counties (92)	Mississippi Counties (91)	Texas Counties (90)
Ashley	Adams	Cass
Chicot	Amite	Harrison
Columbia	Claiborne	Jefferson
Lafayette	Hancock	Marion
Miller	Issaquena	Newton
Union	Jefferson	Orange
	Marion	Panola
	Pearl River	Sabine
	Pike	Shelby
	Walthall	
	Washington	
	Wilkinson	

State Status – check "In (0)" if your *Provider Street Address* is located within Louisiana or "Out (1)" if it is located outside Louisiana.

Location Type – check "Urban (1)" if your *Provider City* is an urban location or "Rural (2)" if it is a rural location.

License # - the license number (if applicable) for the person or business identified in the *Provider Name* field.

Medicare Provider # - enter the Medicare number assigned to the person or entity identified in the *Provider Name* field (if applicable).

UPIN – enter your universal provider identification number, if known.

Specialty Type – enter the specialty type for the individual identified in the *Provider Name* field.

Board Certification #- enter the number relating to your Board Certification – this number is issued by the certifying board and is included on your Board Certification certificate.

Date of Birth – If the *Provider Name* is for an individual, the date of birth for the individual is to be entered here. This is a required field and the forms will be returned for correction if it is left blank.

SECTION B – PAY-TO INFORMATION

For Active Provider Numbers – it is important to indicate if the Pay-To information is to be updated with this application. If it is, consider whether the Direct Deposit information also needs to be updated.

Provider Pay-To Name – enter the name to which you wish payments made – this name must match the top line of your enclosed pre-printed IRS documentation EXACTLY! Do not abbreviate or add punctuation not found on the IRS documentation. If the name **DOES NOT** match the IRS documentation exactly, the application will be returned to you for correction.

Attn or Other – enter the name under which your business does business if different than the name entered in *Provider Name* or the name of the person to whom correspondence should be addressed.

Provider Pay-To Address – enter the address to which you wish your payments and/or remittance advices to be mailed.

Provider Pay-To City – enter the city in which your *Provider Pay-To Address* is located.

Provider Pay-To State – enter the state in which your *Provider Pay-To Address* is located.

Provider Pay-To Zip – enter the zip code in which your *Provider Pay-To Address* is located.

IRS Reporting # – the Tax ID number assigned to your Provider number. This number is used in reporting payment amounts for this provider number to the IRS. A copy of a pre-printed IRS document verifying the number is required.

Provider Year-End Date – enter the Fiscal Year-end month of your business. **This is a required field for all providers who will complete an Annual Cost Report.**

National Provider Identifier (NPI) – once obtained, enter your National Provider Identifier number in this field. Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do for more information on obtaining an NPI.

SECTION C – OWNERSHIP INFORMATION

Practice Type – check the appropriate box for the individual/entity entered in *Provider Name* field.

All Providers Except Hospitals and LTC – if the individual / entity entered in *Provider Name* is not a hospital or long-term care (LTC) facility check the appropriate box for ownership information.

SECTION D – HOSPITALS/LTC FACILITIES ONLY

HOSPITALS/LTC – if the individual / entity entered in *Provider Name* is a hospital, or long-term care facility, check the appropriate box for ownership information. All others leave blank.

Hospitals and LTC Facilities only:

 # Certified Beds – enter the total number of beds that have been certified by the Health Standards unit for this provider.

Name of Facility Administrator - if hospital or LTC facility enter name of facility administrator.

SECTION E

Effective Date – enter the date you wish to have your new Medicaid provider number become effective. Effective date entered will be considered in enrollment process, but cannot exceed Timely Filing Guidelines. All eligibility requirements must be met on the date requested for the date to be considered.

Provider Type Description & Code (Required Field) – Review the following table and enter the provider description and code into this field. Entries of provider types other than those listed in this table will result in rejection of this application.

85	ADHC – Home & Community Based Services
51	Ambulance Transportation
54	Ambulatory Surgical Center
34	Audiologist
45	Case Mgmt – Contractor
8	Case Mgmt - Elderly
46	Case Mgmt - HIV
07	Case Mgmt - Infants & Toddlers
43	Case Mgmt - Nurse Home Visits for First-Time Mothers
48	Case Mgmt - Pregnant Women
81	Case Mgmt - Ventilator Assisted Care Program
30	Chiropractor
30	Chiropractor Group
93	Clinical Nurse Specialist
91	CRNA
27	Dental Group
27	Dentist
40	DME Providers (Out-of-State – Crossovers Only)
19	Doctor of Osteopathy (DO)
19	Doctors of Osteopathy (DO) Group
70	EPSDT Health Services
71	Family Planning Clinic
72	Federally Qualified Health Center
76	Hemodialysis Center
44	Home Health Agency
09	Hospice Services
60	Hospital
69	Hospital - Distinct Part Psychiatric
88	ICF(MR) Group Home
23	Independent Lab
66	KIDMED Screening Clinic
74	Mental Health Clinic
64	Mental Health Hospital (Free-Standing)
77	Mental Health Rehab. (Change of Ownership Only)
25	Mobile X-Ray - Radiation Therapy Center
42	Non-Emergency Medical Transportation
78	Nurse Practitioner
90	Nurse-Midwife
80	Nursing Facility
37	Occupational Therapist (Crossovers only)
75	Optical Supplier
28	Optometrist
28	Optometrist Group
24	Personal Care Services (LTC/PCS/PAS)
26	Pharmacy (Out-of-State – Crossovers only)
35	Physical Therapist (Crossovers only)
20	Physician (MD)
20	Physician (MD) Group
94	Physician Assistant
32	Podiatrist
32	Podiatrist Group
67	Prenatal Health Care Clinic
13	Pre-Vocational Habilitation
31	Psychologist
65	Rehabilitation Center
87	Rural Health Center (Independent)
79	Rural Health Clinic (Provider Based)
38	School Based Health Center
73	Social Worker (Crossovers only)
68	Substance Abuse and Alcohol Abuse Center - (Crossovers only)
29	Title V, Part C Agency Services (EarlySteps)
62	Tuberculosis Clinic
63	Tuberculosis Inpatient Hospital
61	Venereal Disease Clinic
14	Waiver – Adult Day Habilitation
17	Waiver - Assistive Devices
03	Waiver - Children's Choice
15	Waiver – Environmental Modifications
01	Waiver - Fiscal Agent
98	Waiver - Habilitative Supported Employment
06	Waiver - NOW Professional (RN/LPN/PhD/SW)
82	Waiver - Personal Care Attendant
16	Waiver - Personal Emergency Response System
83	Waiver - Respite Care (Center-Based only)
84	Waiver - Substitute Family Care
89	Waiver - Supervised Indep Living

SECTION F

Indicate how the Louisiana Medicaid Provider Number will be used in billing. This will result in Enrollment Status being set as either "0" or "1". See description below.

Enrollment Status "1"

a. Payment may be generated to this provider number for individual professionals. Payments are issued to the Pay-To Name on file.
b. This number may also be used as an attending provider number on group-submitted claims. All payments for claims submitted by a group with the individual provider number identified on the claim as the attending provider will be sent to the submitting group.

Enrollment Status "0" – (Individuals only)

Payments cannot be generated to this provider number for individual professionals. The number may, however, be used as an attending number for group billing. Payments are generated to the submitting group.

SECTION G – PROVIDER ACCEPTANCE OF MEDICAID REQUIREMENTS AND CONDITIONS

Read the information included in this section.

Print Provider's Name - print the name of the individual provider or the authorized agent that will sign this document.

Provider's Signature – **signatures must be original** (stamped signatures and initials are not accepted).

- If this application is for an individual, then the individual must sign and date the form. Office Manager signatures are not accepted.
- If this application is for a business or facility, then the signature must be that of an authorized agent for the business / facility.

Date – enter the date this agreement was signed.

ALL PROVIDERS MUST COMPLETE THE PE-50 FORM IN ITS ENTIRETY – INACCURATE/ INCOMPLETE FORMS WILL BE RETURNED FOR CORRECTION TO THE "PAY-TO" ADDRESS

Louisiana Medicaid Ownership Disclosure Information

A completed Ownership Disclosure form must be submitted with this packet. To complete the Ownership information, please go to www.lamedicaid.com under the Provider Enrollment link and complete the information on line. Once complete, a report will be printed. Sign and date the report and submit it with this enrollment packet.

BHSF Form PE-50
Rev 08/05

(Review Instructions Before Completing)

Louisiana Medicaid PE-50 Provider Enrollment Form

Medicaid Provider # (if known)

This enrollment packet is for a ☐ New Enrollment ☐ Update to Existing Enrollment
☐ Group Linkage Only ☐ Reactivation ☐ Other (Please specify)

Is this a Change of Ownership (CHOW)? ☐ Y ☐ N
See Instructions for definition of CHOW per Louisiana Medicaid policy.
If yes, current LA Medicaid provider number:

A Individual / Entity Information & Physical Location

Provider Name (DBA name if applicable) (Individuals: Last Name, First Name, Middle Initial)	M.D., D.O., etc.	Area Code & Telephone # ( ) -	Social Security # (Required) - -
Physical Street Address - Can Mail Be Received at this address: ☐ Y ☐ N		Mailing Address (if different)	
Physical City	State	Zip Code	Mailing Address City / State / Zip Code
Parish /County	Parish Code	State Status ☐ In (0) ☐ Out (1)	Location Type ☐ Urban (1) ☐ Rural (2) / License #
Medicare Provider # / UPIN		Specialty Type	Board Certification # / Date of Birth (required)

B Pay-To Information

For providers with active provider number: Do you wish to update your Pay-To Address currently on file? ☐ Yes ☐ No
If yes, have you considered if your Direct Deposit information also needs to be updated? ☐ Yes ☐ No

Provider Pay To Name (MUST match IRS document EXACTLY)	Attn or Other		
Provider Pay To Address	Provider Pay To City	Provider Pay To State	Provider Pay To Zip Code
IRS Reporting #	Provider Year-End Date	National Provider Identifier:	

C Ownership

Practice Type (All Providers)

- ☐ Individual (01)
- ☐ Partnership (02)
- ☐ Corporation (03)
- ☐ Hospital Based Physician (04)
- ☐ Health Maintenance Organization (05)
- ☐ Group Practice (Private) (06)
- ☐ Teaching Provider (Physician / Dentist) (07)
- ☐ Public Clinic or Group (08)

All Providers Except Hospitals & LTC (In-State Only)

- ☐ Privately Owned (1)
- ☐ City/Parish Owned (4)
- ☐ Office of Public Health (6)
- ☐ School Board Owned (8)
- ☐ State Owned (9)

D Hospitals & LTC Only

- ☐ Profit (2)
- ☐ Nonprofit (3)
- ☐ Public (4) (In-State Only)
- ☐ Charity (7) (In-State Only)

Certified Beds

Name of Facility Administrator

E

Effective Date Information	Provider Type Description & Code (required)

F

My Louisiana Medicaid provider number will be used for:

- ☐ (0) Group billing only and not for individual billing;
- ☐ (1) Individual billing only;
- ☐ (1) Individual and Group billing.

The following person may be contacted for additional information regarding this enrollment application:

Contact Person

Contact Phone # ( )

G Provider Attestation of Information

I, the undersigned, certify to the following:

1. I have read the contents of this enrollment packet including the PE-50 Addendum and the information contained herein is true, correct and complete;
2. I understand that it is my responsibility to maintain current information on the Louisiana Medicaid files and failure to do so may result in delayed payments or closure of the Medicaid Provider Number;
3. I am either the individual named in Section A or an authorized party for the entity in Section A and can legally bind this entity to this agreement through my signature below; and
4. I understand that the Louisiana Medicaid files will be updated with information supplied on these forms.

Print Provider's Name | **Provider's Signature** | **Date**

ALL PROVIDERS MUST COMPLETE ENTIRE FORM– INCOMPLETE FORMS WILL BE RETURNED FOR CORRECTION

PE-50 ADDENDUM – PROVIDER AGREEMENT

Provider Number (7 digits)
Leave Blank if Applying for New Number

Provider Name

I, the undersigned, certify and agree to the following:

Enrollment in Louisiana Medicaid

1. I have read the contents of this Louisiana Medical Assistance Program Enrollment Packet and the information supplied herein is true, correct and complete;
2. I understand that it is my responsibility to ensure that all information is kept up to date on the Louisiana Medicaid Provider File;
3. I understand that failure to maintain current information may result in payments being delayed or closure of my Medicaid provider number;
4. I understand that if my number is closed due to inaccurate information, I will have to complete a new enrollment packet in its entirety to reactivate my provider number;

Providing Services to Louisiana Medicaid Recipients

5. I agree to abide by Federal and State Medicaid laws, regulations and program instructions that are applicable to the provider type for which I am enrolled. I understand that the payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions;
6. I agree to conduct my activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL) Louisiana R.S. Title 46, Chapter 3, Part VI-A, as required to protect the fiscal and programmatic integrity of the medical assistance programs;
7. I understand that services and/or supplies provided by me must be medically necessary and medically appropriate for each individual patient based on needs presented on the date of service that the service is provided and/or delivered;
8. I agree to charge no more for services to eligible recipients than is charged on the average for similar services to others;
9. I understand that as the provider I am held responsible for any and all claims submitted under any Louisiana Medicaid provider number issued to me;
10. I agree to maintain all records necessary for full disclosure of services provided to individuals under the program and to furnish information regarding those records as well as payments claimed/received for providing such services that the agency, the DHH Secretary, the Louisiana Attorney General, or the Medicaid Fraud Control Unit may request for five years from the date of service;
11. I agree to participate as a provider of medical services and shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by me as a Medicaid patient. I agree to accept a client's Medicaid card as payment in full for covered services rendered. I agree to bill Medicaid for **all** services covered by Medicaid that will be provided to eligible Medicaid clients;
12. I agree to accept Medicaid payment for covered services as payment in full and not seek additional payment from any recipient for any unpaid portion of a bill, with the exception of state-funded spend-down Medically Needy recipients as indicated by the agency's form 110-MNP or any recipient co-payments as established by the DHH;
13. I agree to adhere to the published regulations of the DHH Secretary and the Bureau of Health Services Financing, including, but not limited to, those rules regarding recoupment and disclosure requirements as specified in 42 CFR 455, Subpart B;
14. I agree to adhere to the federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the federal Department of Health and Human Services, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA;

-- continued --

15. I understand the Louisiana Medicaid Program must comply with DHHS regulations promulgated under Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; and the American Disabilities Act of 1990 which require that:
    - No person in the United States shall be excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of age, color, handicap, national origin, race or sex under any program or activity receiving Federal financial assistance.

    Under these requirements, Louisiana's Department of Health and Hospitals, Bureau of Health Services Financing cannot pay for medical care or services unless such care and services are provided without discrimination based on age, color, handicap, national origin, race or sex. Written complaints of non-compliance should be directed to Secretary, Department of Health and Hospitals, PO Box 91030, Baton Rouge, LA 70821-9030 or DHHS Secretary, Washington, DC or both.

Medicaid Direct Deposit (EFT) Authorization Agreement

16. I have reviewed the Medicaid Direct Deposit (EFT) Authorization Agreement and the Medicaid Provider Requirements and Conditions as listed below and agree to this agreement:
    - I/We understand that payment and satisfaction of any claims will be from Federal and State Funds; and any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.
    - I/We understand that DHH may revoke this authorization at any time.
    - I/We hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments that the payee has rendered for Medicaid services.
    - I/We certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature(s) below is authorized by the stated Board of Directors to enter into or change this agreement.
    - I/We agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I/We further understand that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility and failure to notify the Provider Enrollment Unit as noted may result in Medicaid payments being electronically transmitted to incorrect accounts. I understand that such changes may not be able to be accommodated if less than 15 business days notice is given.

Certification of Claims (Paper & Electronic)

17. I certify that all claims provided to Louisiana Medicaid recipients will be necessary, medically needed and will be rendered by me or under my personal supervision;
18. I understand that all claims submitted to Louisiana Medicaid will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws;
19. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate, and complete.

Print Name of Provider or Authorized Agent	Title / Position
Signature of Provider or Authorized Agent (stamps, initials not acceptable)	Date of Signature

LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

(COMPLETION INSTRUCTIONS)

1.	Medicaid Provider Number:	Enter your **FULL 7-DIGIT** LA Medicaid Provider Number **(Only one provider number per form)**
2.	Provider Name:	Enter the name in which you are enrolled as a LA Medicaid Provider
3.	National Provider Identifier	Once obtained, enter the 10-digit National Provider Identifier
4.	Contact Name of Person Completing Form	Enter the name of the individual you will designate as the contact for Medicaid direct deposit issues.
5.	Contact Person's Phone Number:	Enter the phone number through which we may contact the individual listed in number 4 above.
6.	Account Type	Check the appropriate block (only one) to indicate the type of account to which your direct deposit will be transferred.
7.	Reason for Change in Account Information	Give a brief description of why the EFT information is being updated.
8.	Voided Check:	Tape a copy of a voided check showing the ABA routing number and account number. *Deposit slips are not accepted.* If a voided check is unavailable, a letter on bank letterhead identifying the ABA routing number, account number and type of account may be substituted.
9.	Signature, Title, Date	Enter your full signature, title of the person authorized to sign and date of signature. **ORIGINAL SIGNATURES ONLY; NO STAMPS OR COPIED SIGNATURES WILL BE ACCEPTED. INDIVIDUAL PROVIDERS MUST SIGN THEIR OWN FORMS.**

Please be sure to complete this form in its entirety. It will not be accepted for processing and will be returned to you if any field is incomplete.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

1. Medicaid Provider Number (7 digits)

2. Provider Name

3. National Provdier Identifier (Once Obtained) (10 digits)

4. Contact Name of Person Completing Form:

5. Contact Person's Phone Number:

ACCOUNT INFORMATION

(All fields must be completed)

6. Account Type: *(Check One)*
☐ CHECKING ☐ SAVINGS

7. Reason for change in account information:

8. Attach Copy of Voided Check (Deposit Slips are not Acceptable)

TAPE COPY OF VOIDED CHECK HERE – NO STAPLES
DEPOSIT SLIPS ARE NOT ACCEPTED

** ***To avoid interruption in payment, DO NOT close current account until a direct deposit has been processed into new account.***

If a voided check is unavailable, you may submit a letter on Bank Letterhead stating the ABA Routing Number and Account Number. The letter must be signed by a Bank Representative.

* **Attach a voided check (deposit slip not acceptable) showing complete account number and routing (ABA) number**. Original signatures required (stamped signatures or initials not accepted). If joint account, **BOTH** owners must sign this request form.

- I/We understand that payment and satisfaction of this claim will be from Federal and State Funds and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws. I/We understand that DHH may revoke this authorization at any time.
- I/We hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account referenced above and depository named above. These credits will pertain **only to direct deposit transfer payments** that the payee has rendered for Medicaid services.
- I/We certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature(s) below are authorized by the stated Board of Directors to enter into or change this agreement.

9. Signature | Title | Date

Signature | Title | Date

Mail Original Only to:
UNISYS PROVIDER ENROLLMENT UNIT
PO BOX 80159
BATON ROUGE, LA 70898-0159

BE SURE THAT ALL FIELDS ARE COMPLETED

BHSF PE-DD1

Claims Submission via Electronic Media Claims (EMC/EDI)

Advantages of Electronic Submission

Electronic media claims submission *significantly reduces the time for payment,* because:

- electronic media claims have been pre-edited for errors, they *have a much higher payment ratio;* and
- claims with errors are automatically denied and returned to the provider immediately for corrections.

Submission of claims via electronic media has the following advantages over hard-copy (paper) billing:

- Increased cash flow
- Improved claim control
- Decrease in time from submission to payment
- Automation of receivables information
- Improved claim reporting by observation of errors
- Reduction of error through pre-editing claims information

LAMEDICAID.COM

The election to submit claims via electronic media requires "Provider's Election to Employ Media Submission of Claims for Processing in the Louisiana Medical Assistance Program" and may also include a "Medicaid Electronic Media Limited Power of Attorney" which is located on the Louisiana Medicaid website, http://www.lmmis.com/provweb1/HIPAABilling/HIPAAindex.htm. Click on HIPAA Billing Instructions and Companion Guides and choose EDI General Companion Guide.

- Review the packet in its entirety before completing forms. Incorrect/ incomplete forms will be returned for correction.

- The website contains additional information such as HIPAA Companion Guides, Provider Training Materials, Billing Information, etc.

- If you do not have Internet access, please call Provider Relations at 800/473-2783 to request an EMC/EDI Enrollment Packet.